Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Contract Audit Requirements

The following language from the FY 06 contracting template applies to contractors of DDP waiver funded services:

8.1 The Contractor, in accordance with 18-4-311, MCA and other authorities, must maintain for the purposes of this Contract an accounting system of procedures and practices that conforms to Generally Accepted Accounting Principles (GAAP), as interpreted by the Department, and to any other accounting requirements the Department may require.

8.2 The Department or any other legally authorized governmental entity or their authorized agents may at any time during or after the term of this Contract conduct, in accordance with 5-13-304, MCA and other authorities, audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the Contractor through this Contract and assuring the appropriate administration and delivery of services provided through this Contract.

8.3 The Contractor, for purposes of audit and other administrative activities, in accordance with 18-1-118, MCA and other authorities, must provide the Department and any other legally authorized governmental entity or their authorized agents access at any time to all the Contractor's records, materials and information, including any and all audit reports with supporting materials and work documents, pertinent to the services provided under this Contract until the expiration of six (6) years from the completion date of each respective state fiscal year.

8.4 The State and any other legally authorized governmental entity or their authorized agents may record any information and make copies of any materials necessary for the conduct of an audit or other necessary administrative activity.

8.5 A non-profit contractor, if receiving $500,000 or more in federal funds from any and all federal funding sources, must comply with the accounting and audit requirements of Federal Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" and the provisions of OMB Circular "A-122, Cost Principles for Non-Profit Institutions" concerning the use of the funds provided under this Contract.

8.6 A for-profit contractor must comply with the accounting and audit requirements in 45 CFR 74.26(d) and the cost principles and procedures for commercial organizations in 48 Subpart CFR 31.2 concerning the use of the funds provided under this Contract in the version in effect on the date this Contract is signed by both parties. Pursuant to 45 CFR 74.26(d), a "for-profit" organization may either have an audit conducted in accordance with the Federal Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" or the Government Auditing Standards.

For non-profit corporations receiving $500,000 or more in federal funds from any and all funding sources, or for-profit corporations, the contractor is responsible to have yearly audits conducted in accordance contract provisions (above). The DPHHS Quality Assurance Division conducts annual desk reviews of these audits to identify substantial risk in integrity and to establish the effectiveness of the corporations internal controls.

For non-profit corporations receiving less than $500,000 in federal funds from any and all federal funding sources, the Quality Assurance Division is responsible to conduct limited scope audits of agreed upon procedures.

Rates Project

The Quality Assurance Division is in the process of developing a Service Utilization Review (SURS) methodology based on input from project and DDP staff. This review process will replace the auditing procedures outlined above

for all providers participating in the rates methodology project. The SURS process will help ensure the integrity of provider invoicing, based on assurances that contracted hours are being delivered.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. The review of a sample of paid claims histories is currently incorporated in the adult QA review process, but is not part of the review of children's services. This will be added to C&F reviews effective 7/1/08.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews and interviews with families and consumers will be used to help verify that provider invoices match actual services delivered effective 7/1/08.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = To be developed
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Isolated auditing issues may be documented and resolved via the Quality Assurance Observation Form process. More systematic auditing problems generally result in a State level audit. If poor business practices are in evidence, the Department may require the development of a corrective action plan and compliance with agreed upon timeframes for resolution of the problems. Fraud, or more egregious problems could result in the return of funds to the State and/or termination of the Department contract. These issues are reported in the QA Review Reports for the agency, and summarized by agency in the CMS 372 reports.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

	Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- **No**
- **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The implementation of a fully compliant V3.5 Quality Improvement Strategy data reporting methodology will be effective 7/1/10, contingent upon CMS approval of the Department's waiver amendment request.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The DDP Regional Managers negotiate contracts with providers through the annual contracting process. The rates methodology system applies to all provider contracts effective 7/1/08. The contracts will not change significantly from year to year by provider, although contract adjustments in the rates for services may occur based on legislative appropriations for general provider rate increases and/or direct care staff salary enhancements.

There is opportunity for input and testimony via various forums and public notices related to the rate setting process. The rates advisory committee
is the primary entity responsible for reviewing data and assisting the DDP in setting rates. The rates advisory committee comprised of DDP staff, the rates contractor, providers, a family member, a Legislator, as well as members from advocacy groups such as Disability Rights Montana, People First, and Montana Council on Developmental Disabilities. Lastly, the rates advisory committee included the liason of the Montana Association of Contractors of Developmental Disabilties Services provider group. The rates advisory committee generally met monthly until 2007. As of 5/08, the committee currently meets on a quarterly basis.

37.34.913 MEDICAID HOME AND COMMUNITY
SERVICES PROGRAM: REIMBURSEMENT (1) Reimbursement under the Medicaid home and community services program is only available for services specified in the recipient's individual plan of care.

(2) Reimbursement for services is at those rates that are available under the terms of the contract that the department enters into with providers of services.

A brief history of the rate setting project follows:

In the fall of 2000, CMS regional office reviewers noted that rates paid for services were not consistent across providers for the similar services. In response to CMS requests for justification of the various rates paid to providers for similar services, DDP elected to establish a new rate and reimbursement methodology. A contractor was hired to assist the State with this process. Currently, waiver recipients in DDP Region 2 are being served in accordance with the methodologies developed under the project. Policies and rules will be developed as the efforts of providers, Davis/Deshaies rates contractor staff, State staff and others refine the definitions and process on an ongoing basis.

The Montana Developmental Disabilities Program has fully converted its provider reimbursement approach from a negotiated rate system to a standardized fee-for-service system for its Medicaid Home and Community-Based Services (HCBS) waiver program effective 7/1/08. This conversion has been initiated in response to direction from

the Montana State legislature and guidance from the federal Centers for Medicare and Medicaid. There are three major components to the DDP rate initiative:

1. Direct Care Staff Time as the Billable Unit: With the exception of adaptive equipment / environmental modifications and transportation, all provider reimbursement is based upon the amount of direct care staff time delivered to the consumer by the provider. In order to meet the conditions for payment, the consumer must be Medicaid eligible, enrolled, in attendance, and receive a HCBS service; and the direct care staff must be actively employed and providing the specified service as outlined under the unit definition and plan of care.
• Direct Care Staff Definition: Direct care staff are those individuals whose primary responsibility is the day to day support of people with disabilities, training and instruction, and assistance with and management of activities of daily living. Direct care workers can be either employees of an agency, or may be self-employed, so long as 85% of their work activities include daily supports to people with disabilities.

• Billable Unit: The term "billable unit" is used to describe the amount of service provided. The term "Hours" refers to a Direct Care Staff Hour. For services using this billable unit, agencies are reimbursed for each direct care staff hour provided. The term "Month" refers to a single month billing unit. For services using this billable unit, agencies are reimbursed a fixed monthly amount for all direct care hours provided to those people enrolled in their service for an entire month. Monthly rates are used when individual support needs can widely vary on a daily basis.

2. Standardized Cost Centers: All provider reimbursement rates consist of four cost centers. These cost centers are:

---Direct Care Staff Compensation

---Employee-Related Expenses

---Program Supervision and Indirect Expenses

---General & Administrative Expenses

In addition to the standardized cost centers, geographical factors are applied for residential habilitation and day habilitation services; economy-of-scale and holiday factors are applied to residential habilitation. These factors are as follow:

• Geographical factor: Geographical cost adjustment factors consider the cost of living, employment compensation, cost of housing, and labor market trends.

• Economy-of-Scale factor: Economy-of-scale factors are used to adjust provider reimbursement for general & administrative (G&A) and program-related (PR) costs for agencies of different sizes.

• Holiday Coverage factor: Each residential provider may identify up to ten (10) holidays per fiscal year; direct care staff hours provided on those days will be compensated at 1.5 times normal salary which providers must pass on to direct care staff.

HB2 of the 2005 Legislative Session supported the gradual implementation of published rates as outlined:

"Funding for the Disability Services Division includes funding that supports community services for developmentally disabled individuals and the implementation of a statewide published rate schedule for reimbursement of these services. Funding for these services was appropriated by the legislature in a manner that supports a phased-in implementation of the published rate schedule, with one-quarter of the reimbursement for services provided to consumers transitioning to the published rate schedule each year. The department may adjust the timeframe for implementation of the published rate schedule if necessary to maintain federal Medicaid funding, avoid federal penalties, or achieve compliance with federal requirements. In the event that the timeframe for implementation of the published rate schedule is modified, the department shall notify members of the 2005 legislative joint appropriations subcommittee on health and human services prior to taking action to change the implementation schedule."

On January 1, 2005, DDP initiated Phase I of the rates pilot program that lasted through June 30, 2005. Due to the findings during this pilot, several adjustments were made to the rates and assessment tool to better accommodate the needs of providers and consumers.

Starting July 1, 2005, a Phase II pilot was initiated, which involves all adult providers in Region II (consisting of approximately 320 individuals in services). Based on legislative comments in HB2, the prior pilot findings, and updated provider information, the rates were adjusted to accommodate budget neutrality and are currently being tested and validated.

Coinciding with provider rates is the development of a resource allocation tool, otherwise known as the MONA. The MONA is a tool to allocate funding to individuals in services. This tool was also updated from the original pilot, and is further being tested during the current pilot in Region II.

The Phase II pilot ended on June 30, 2006. After the end of the Phase II pilot, the extant rates and assessment tool were finalized and published. Region II then began operation under the published rates. DDP continued the rates implementation plan an implementation plan for rate structure as designated by HB2. Starting July 2006, (FY2007) about 900 more individuals entered into the published rate system from Regions I and III. On July 1, 2008, Regions IV and V enter the rates system, and the rates methodology projected will be fully implemented. New rules reated to the rates system are currently in draft form.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Flow of Billings

All DDP contractor billings flow directly from the contractor to the Department, and are entered into AWACS.

Individuals must be Medicaid eligible and enrolled as Waiver Other (WO) on the Waiver Access Client Information (WACI) screen of TEAMS, the electronic link to the MMIS. TEAMS maintains electronic public benefits information, Medicaid enrollment and DD Waiver enrollment status. The DPHHS-DD/MA-55 Form is used by DDP field staff and the county Office of Public Assistance (OPA) Eligibility Technician to open the individual as Waiver Other (WO) on the WACI screen. The WACI screen is a dedicated screen in the TEAMS system maintaining the date(s) of enrollment and dis-enrollment in Montana's waivers.

The start date on the MA 55 Form corresponds to the date of enrollment in the DD Waiver. Pre-printed invoices are issued to service providers by the DDP after the initial Individual Service Record (ISR) form is sent from the Provider to the DDP Regional Office. These invoices are completed on a monthly basis by providers, and then forwarded to the Regional Offices, where they are verified for accuracy and entered into the Agency Wide Accounting and Client System (AWACS). The AWACS invoicing system is tied to the public benefits information database via a link serving to notify the worker of individuals either not currently enrolled in the waiver and/or currently eligible for Medicaid.

Invoices are then forwarded to the DDP central office, approved for payment and the electronic information is sent to fiscal for payment via the statewide accounting and payments system (SABHRS). Hard copies of provider invoices are maintained at the DDP central and regional offices. Individual paid claims histories are maintained in the AWACS database indefinitely.

Linkage to ensure that individuals are not eligible to receive duplicated educational services under IDEA or duplicated services available from Vocational Rehabilitation (VR) is the responsibility of the assigned developmental disabilities case manager. The vast majority of individuals in this waiver have aged out of eligibility for school services. Given that the Waiver is payer of last resort and that funds are limited, planning team members have demonstrated due diligence in exploring all potential funding sources for needed services prior to committing waiver cost plan dollars.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (•) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services**

and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Payments are made to reimburse providers for services to persons enrolled and eligible for Medicaid at the time services were rendered. This is accomplished by the electronic link between AWACS and TEAMS. See Section C, above. If a person is not Medicaid eligible at the time the payment is approved by the DDP regional office administrative assistant, the name of the ineligible recipient is highlighted. Payments are normally reviewed and approved monthly.

The AWACS service option codes are loaded onto prepaid invoices based on the most recent Individual Service Record (ISR) form loaded into AWACS. These ISRs reflect service categories, and not necessarily specific supports within those categories. At the time that services are approved for payment, there is no third party review of the accuracy or validity of the provider's claim for reimbursement, but the recipient is verified in terms of being enrolled in the waiver, and currently eligible for Medicaid. Failure to deliver services specified in the plan of care may not be caught during the monthly billing process, but audit exceptions and QA discoveries can and have resulted in provider back payments.

In the rates system, the SURS process conducted by the Quality Assurance Division will help ensure the financial integrity of provider billing practices.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

The response to a, b, and c, above are explained in section I-2 b.

(d) The basis for the draw of federal funds and the claiming of expenditures on the CMS-64 follows:

When the expenditures identified in I-2.b. post to the Statewide Accounting Budgeting Human Resource System (SABHRS), federal funds are drawn down from the Smartlink system, via the Internet. Medicaid is a Cash Management Improvement Act (CMIA) grant; therefore, electronic fund transfers are drawn for immediately, and warrants are drawn on a six day clearance pattern. These expenditures are claimed on the appropriate waiver form on the CMS-64, which is then reconciled quarterly to the SABHRS system.

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

The only public providers receiving payment from the DDP for waiver services are the public transportation providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) Entities are designated as OHCDS in the provider contract. Providers are designated as OHCDS in cases where the provider with the DD Contract subcontracts with other entities (persons or agencies) for the provision of services not provided by staff employed by the agency contracting with the DDP. Any person or agency providing services under a subcontract with an agency with a DDP contract must meet the DDP qualified provider standards for the provision of the service. It is the responsibility of the agency with the DDP contract to ensure the QP standards for the subcontracted service are met and documentation is maintained by the agency with the OHCDS designation to support this requirement.
(b) Providers of waiver services may choose to contract directly with the DDP. The potential service provider would request a provider enrollment package from the DDP. After the required enrollment documentation has been reviewed and approved by the DDP Regional Manager and subject to a successful on onsite review of the physical site (if applicable) by the DDP, the applicant would achieve qualified provider status. The provider would then be enrolled as a Montana Medicaid Provider, although payment would flow through AWACS (Agency Wide Accounting and Client information System) and not through the MMIS.
(c) Service recipients are free to request the services of any qualified provider, as outlined in previous sections. Case managers are responsible for providing information to recipients and families regarding available service providers as part of the planning and pre-planning meeting process. Providers currently subcontract with various providers of professional and therapy services, in response to the expressed desires of the recipient and/or family.
(d) All expenses associated with subcontractor payments are reported on the monthly invoices. These expenses may be discreet or bundled depending on the AWACS service option code assigned to the service category. Providers must break out, or "unbundle" AWACS service categories, as needed, to report the delivery of all waiver services by waiver service category in the provider Annual Expenditure Reports (AERs). This information is a critical piece of the paid claims history and audit trail, and is subject to review by independent, state and federal auditors.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

○ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

● **Applicable**

Check each that applies:

☑ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

In accordance with MCA 53-20-208, counties may access local tax levies for the purpose of supporting

local services to persons with developmental disabilities. These funds are not matched with Medicaid. 53-20-208. Contributions of counties and municipalities. (1) The boards of county commissioners of the several counties and the governing bodies of municipalities of this state may contribute to any developmental disabilities facility approved by the department, without regard to whether the facility is within or outside of their respective jurisdictions. Subject to 15-10-420, the boards of county commissioners of the counties may levy a tax on the taxable value of all taxable property within the county. The tax is in addition to all other county tax levies. All proceeds of the tax, if levied, must be used for the sole purpose of support of developmental disabilities services.

(2) For the purpose of carrying out the provisions of this section, boards of county commissioners and governing bodies of municipalities may appropriate out of the general fund of their respective counties or municipalities.

History: En. 80-2619 by Sec. 9, Ch. 325, L. 1974; Sec. 80-2619, R.C.M. 1947; amd. and redes. 71-2408 by Sec. 7, Ch. 239, L. 1975; R.C.M. 1947, 71-2408; amd. Sec. 131, Ch. 584, L. 1999; amd. Sec. 159, Ch. 574, L. 2001.

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The cost of room and board is not reimbursable as a waiver expense, in accordance with the waiver service definitions. The amount charged to a recipient for room and board in a group home setting may leave the individual with insufficient personal funds. State General Fund supplemental payments enable a provider to cover costs associated with room and board expenses above and beyond a recipient's ability to pay with personal benefits income. In turn, the provider is responsible for ensuring recipients have personal needs money.

Currently, providers are reimbursed for the provision of waiver services under the terms of the provider contract for group home or supported living recipients based on service option codes and the number of recipients to be served. The providers are accountable for the expenditures of waiver funds as outlined in the associated rules, codes, contract and waiver language. Auditing requirements assist in ensuring that funds expended are in accordance with generally accepted accounting principles.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (•) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (•) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64: